Exhibit A

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

SHEET METAL WORKERS
NATIONAL HEALTH TRUST FD.
P.O. BOX 1449
GOODLETTSVILLE TN 37070

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA ☐☐ | PICA ☐☐

PVA File # ☐ | GROUP HEALTH PLAN (SSN or ID) ☐ | FECA BLK LUNG (SSN) ☐ | OTHER ☒ (ID) | INSURED'S I.D. NUMBER | (FOR PROGRAM IN ITEM 1)

PATIENT AND INSURED INFORMATION

3. PATIENT'S BIRTH DATE MM DD YY: 08 14 14	SEX: M ☒ F ☐		
6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐			
CITY: SPRINGFIELD	STATE: MA	SPRINGFIELD	MA
8. PATIENT STATUS: Single ☐ Married ☒ Other ☐			
ZIP CODE: 01104	TELEPHONE (Include Area Code):	ZIP CODE: 01104	TELEPHONE (INCLUDE AREA CODE):
Employed ☐ Full-Time Student ☐ Part-Time Student ☐			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): SEPARATE	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: RETIRED	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY: 08 14 [redacted] SEX: M ☒	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 08 14 [redacted] SEX: M ☒	b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME: RETIRED	
c. EMPLOYER'S NAME OR SCHOOL NAME: RETIRED [redacted]	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE PART B CLAIMS	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☒ YES ☐ NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 06/04/04

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DANIEL DRESS, M.D.	17a. I.D. NUMBER OF REFERRING PHYSICIAN: 083074	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO — $ CHARGES: .00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 185 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 12 04		3	1	99213	25	1	60.00	1.0				
2 05 12 04		3	1	J9202		1	1275.00	3.0				
3 05 12 04		3	1	96400		1	75.00	1.0				
4 05 12 04		3	5	81000		1	20.00	1.0				
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
043249509	☐ ☒	51943	☒ YES ☐ NO	$ 1430.00	$ 1000.53	$ 251.01

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
J MICHAEL DECENZO, M.D. SIGNED 06/04/04 DATE	PIONEER VALLEY UROLOGY PC 299 CAREW STREET SPRINGFIELD MA 01104	[redacted] PIONEER VALLEY UROLOGY PC 2 MEDICAL CTR. DR. STE. 300 SPRINGFIELD MA 01107-1280 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M16033
CHECK/EFT #:127575349 05/28/04

127575349 100000355
PIONEER VALLEY UROLOGY
PAGE #: 9 OF 10

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-ANT	PROV PD
NAME [redacted]										ASG Y MOA MA01	
J053[redacted]	0512 051204	11	1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	0.00				CLAIM TOTALS	20.00	4.43	0.00	0.00	15.57	4.43
											4.43 NET
[redacted]										ASG Y MOA MA01 MA18	
J[redacted]	[redacted]	11	1	99213 GY		60.00	55.97	0.00	11.19 CO-42	4.03	44.78
PT RESP	11.19				CLAIM TOTALS	60.00	55.97	0.00	11.19	4.03	44.78
											44.78 NET
NA[redacted]										ASG Y MOA MA01 MA07	
J05[redacted]	0513 051304	11	1	99211		30.00	23.15	0.00	4.63 CO-42	6.85	18.52
J05335	0513 051304	11	1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
J05335	0513 051304	11	1	99000		8.00	0.00	0.00	0.00 CO-B15	8.00	0.00
REM: M80											
PT RESP	4.63				CLAIM TOTALS	58.00	27.58	0.00	4.63	30.42	22.95
											22.95 NET
NAM[redacted]										ASG Y MOA MA01 MA07	
API[redacted]	[redacted]	11	1	99213		60.00	47.57	0.00	9.51 CO-42	12.43	38.06
PT RESP	9.51				CLAIM TOTALS	60.00	47.57	0.00	9.51	12.43	38.06
											38.06 NET
N[redacted]										ASG Y MOA MA01 MA18	
A23499	[redacted]					60.00	55.97	0.00	11.19 CO-42	4.03	44.78
A23499	0513 051304	11	1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	11.19				CLAIM TOTALS	80.00	60.40	0.00	11.19	19.60	49.21
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											49.21 NET
N[redacted]										ASG Y MOA MA01 MA07	
A23499	0513 051304	11	1	99243 25		150.00	127.05	0.00	25.41 CO-42	22.95	101.64
A23499	0513 051304	11	1	52310		750.00	261.07	0.00	52.21 CO-42	488.93	208.86
A23499	0513 051304	11	1	A4550		80.00	0.00	0.00	0.00 CO-B15	80.00	0.00
REM: M80											
PT RESP	77.62				CLAIM TOTALS	980.00	388.12	0.00	77.62	591.88	310.50
											310.50 NET
[redacted]										ASG Y MOA MA01 MA07	
[redacted]	[redacted]					60.00	55.97	0.00	11.19 CO-42	4.03	44.78
A23499	0513 051304	11	1	53600		150.00	97.35	0.00	19.47 CO-42	52.65	77.88
A23499	0513 051304	11	1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
A23499	0513 051304	11	1	87088		30.00	11.31	0.00	0.00 CO-42	18.69	11.31
PT RESP	30.66				CLAIM TOTALS	260.00	169.06	0.00	30.66	90.94	138.40
											138.40 NET
NAI											
N51618	0512 051204	11	1	99213 25		60.00	55.97	0.00	11.19 CO-42	4.03	44.78
N51618	0512 051204	11	3	J9202		1275.00	1127.97	0.00	225.59 CO-42	147.03	902.38
N51618	0512 051204	11	1	96400		75.00	71.17	0.00	14.23 CO-42	3.83	56.94
N51618	0512 051204	11	1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	251.01				CLAIM TOTALS	1430.00	1259.54	0.00	251.01	170.46	1008.53
											1008.53 NET
NAME										A01	
N51618	0512 051204	11	1	87088		30.00	11.31	0.00	0.00 CO-42	18.69	11.31
PT RESP	0.00				CLAIM TOTALS	30.00	11.31	0.00	0.00	18.69	11.31
											11.31 NET
N[redacted]										ASG Y MOA MA01	
J05335	0512 051204	11	1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	0.00				CLAIM TOTALS	20.00	4.43	0.00	0.00	15.57	4.43
											4.43 NET
NA[redacted]										ASG Y MOA MA01	
J05335	0512 051204	11	1	87088		30.00	11.31	0.00	0.00 CO-42	18.69	11.31
PT RESP	0.00				CLAIM TOTALS	30.00	11.31	0.00	0.00	18.69	11.31
											11.31 NET
[redacted]										ASG Y MOA MA01 MA15	
J05335	0108 010804	11	3	J9202		1275.00	1127.97	9.81	223.63 CO-42	57.30	277.61
									OA-23	907.66	
									PR-23	-233.44	
									CO-23	-57.30	
									CO-35	89.73	
PT RESP	0.00				CLAIM TOTALS	1275.00	1127.97	9.81	223.63	763.95	277.61
											277.61 NET

RECEIVED
JUN 2 2004

HIGHLY CONFIDENTIAL
SMWMASS 000220

[redacted] Employee

04-3249509 51943

REDACTED

20

07/01/2004
Date Issued

Amount Paid: $251.01

SPRINGFIELD, MA 01101

REDACTED

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2563313**

Check No. **1105906**

Explanation of Benefits

SMW+ Program

Dates of Service From	To	Amount Charged	Plan Covered	Charges Allowed	Co-Pay/ Ded/ Not Med	Net Plan Paid
05/12/2004	05/12/2004	$1,430.00	$0.00	$251.01	$251.01	$251.01
[redacted]						

Comments:

REDACTED

[redacted]

PIONEER VALLEY UROLOGY PC
2 MEDICAL CTR DR
STE 308
SPRINGFIELD, MA 01107

Provider: PIONEER VALLEY UROLOGY PC
Participant SSN:
VLC Claim Number: 2563313

Processed by *Southern Benefit Administrators, Inc.*